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CONGRESSIONAL TESTIMONY

Making Health Care Work for American Families: Saving Money, Saving Lives

Testimony before
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My name is Dennis Smith. I am a Senior Research Fellow in Health Care Reform at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

Thank you for the opportunity to participate in your important series of hearings, *Making Health Care Work for American Families.* I will focus my remarks on savings and quality in Medicaid as they relate to the discussion of a government health plan and offer some specific recommendations to include Medicaid long-term care as part of reform that will contribute to the theme of this hearing, *Saving Money, Saving Lives*.

One of the goals of health care reform, as repeated in the title of this hearing, is to save money. President Obama has previously promised that health care reform will save the average family $2,500. To deliver on that promise will mean reducing the cost of health care by over $2 trillion over the next ten years. According to the Milliman Medical Index, the total medical cost for a typical family of four covered by an employer-sponsored preferred provider organization (PPO) was $15,609 in 2008, a 7.6 percent increase from 2007.[1] The cost of private insurance includes the individual's own utilization of health care services, risk of future use, and cost shifting that occurs from indigent care and low provider reimbursement in government programs. In addition to the cost of their own health care, families also subsidize those on Medicaid. Medicaid costs about $5,000 per family that has income above the poverty level. Thus, families are understandably excited about promises to lower the cost of health care.

Medicare and Medicaid account for approximately 45 percent of health care expenditures which will increase to more than 50 percent in the near future. Any serious attempt to lower the cost of health care must therefore include reform of the entitlement programs. It is important to remember in today's environment that health care in the United States is already highly regulated at the federal, state, and local levels. For example, recent regulations now govern compensation that can be paid to agents or brokers under Medicare Part C and Part D plans.[2] Government regulates both supply and demand through provider enrollment, certificate of need, eligibility requirements, and a myriad of other ways.

Health care is also heavily subsidized. For example, Medicare beneficiaries pay only 25 percent of the cost of their Part B premiums. Most states charge little or no cost sharing in their Medicaid and State Children's Health Insurance Programs (SCHIP), relying almost exclusively on taxpayer subsidies. Taxpayers rightfully expect that government assistance programs are administered as efficiently as possible. When we lament what "run-away" health care costs are doing to family, state, and federal budgets,

[1] Milliman Research Report, 2008 Milliman Medical Index, May 2008, p. 3.

[2] Centers for Medicare and Medicaid Services, Federal Register, Vol. 73, No. 221, November 14, 2008. Compensation includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of a policy including, but not limited to, commissions, bonuses, gifts, prizes, awards and finders fees. Compensation does not include the payment of fees to comply with State appointment laws, training, certification, and testing costs; reimbursement for mileage to, and from, appointments with beneficiaries; or reimbursement for actual costs associated with beneficiary sales appointments such as venue rent, snacks, and materials.

we need to acknowledge how governments' own roles as financiers, regulators, purchasers, and competitors contributes to those costs.

As Congress considers the role of a government health plan in health care reform, it would be helpful to look at the history of government as a health care provider and that of Medicaid. Historically, state and local hospitals, nursing homes, and clinics have participated as health care providers. Public hospitals experienced a boom after World War II aided by government-financed construction. Use of hospital outpatient departments increased more than 300 percent between 1944 and 1965.[3] The delivery of health care entered a new phase in the 1960s as population shifts occurred between urban and suburban areas. As a result, "… many of the largest public hospitals became stages of conflict where physicians, nurses, and hospital staff struggled to provide adequate care in deteriorating physical plants that were often ill-equipped and poorly provisioned."[4] The impact of Medicare and Medicaid hit public hospitals in the early 1970s as health care choices expanded. Given a choice of hospitals and doctors, millions of Americans voted with their feet and left the public hospital system. During the 1970s and 1980s, many governmental entities determined that they could no longer afford the significant public subsidies necessary to govern or support large government facilities. Government officials were also concerned about the cost of future obligations associated with retiree benefits. In some cases, the value of the land on which many government facilities were located was viewed as potential source of revenue and economic development and thus provided an incentive to sell assets. Across the country, for these reasons and others, government divested itself from the direct delivery of health care.

Where government health care institutions lingered in states as diverse as California, Louisiana, and New York, state and local governments struggled with quality and cost issues at major institutions even in recent years. After years of failing quality of care surveys, Martin Luther King, Jr. Hospital (MLK Hospital) in Los Angeles was dramatically downsized and all but closed in August 2007. Burdened with massive debt associated with decades of denial and refinancing, New York ultimately adopted the December 2006 recommendations of its Commission on Health Care Facilities in the 21st Century. By the end of the transformation process in 2011, one-fourth of all hospitals in New York will be reconfigured. Approximately 2,800 nursing home beds will be eliminated.[5]

Some have argued that a new government plan modeled after Medicare is essential to health care reform because "… public insurance has a better track record than private insurance when it comes to reining in costs …".[6] The premise that government will be more business minded or better negotiators than the private sector and therefore will dispassionately lower costs below the market is highly questionable. Proponents are

[3] National Association of Public Hospitals and Health Systems, *The Safety Net*, Spring 2006, p. 9
[4] Ibid, p. 9.
[5] See New York State Department of Health, *Report on Implementation of the Report of the Commission on Health Care Facilities in the Twenty-First Century*, 2008.
[6] Jacob Hacker, Ph.D., Institute for America's Future, *The Case for Public Plan Choice in National Health Reform, Key to Cost Control and Quality Coverage*, 2008, p.1.

asking us to suspend decades of experience to the contrary. Conversely, if the benchmark of reform is controlling costs, and one thinks Medicare is superior to the private sector, then Medicaid must be even better yet because Medicaid pays its providers even less than Medicare. Medicaid's record at controlling costs includes the facts that there are major gaps in access to care and that providers leave the program. Just this week, Reuters reports that major pharmacies in Washington State are pulling out of the Medicaid program.[7]

In the current discussion over whether a government health plan should be created as an alternative to private plans, we would do well to consider why states are moving away from traditional Medicaid towards increased use of contracts with the private sector. The very reason states are changing their strategies seems to have been lost in the debate. They are doing so to improve quality and lower costs compared to the traditional model of government run health care under which government defines the benefits, recruits providers, sets payment rates, and determines how much individuals will pay for coverage.

There is no shortage of quality initiatives pursued by federal and state governments in Medicare and Medicaid. We are not suffering from a lack of ideas nor lack of regulation in Medicare and Medicaid. How regulations can stifle quality is rarely discussed. Furthermore, Federal, state, and local officials are often presented with competing interests, including that someone benefits financially from inefficiencies in the delivery system that so many now oppose. The Centers for Medicare and Medicaid Services (CMS), for example, had an initiative to put the delivery of durable medical equipment out for competitive bidding. Such efforts were eventually blocked. Officials are confronted with enforcement dilemmas when deciding about what action will cause the least amount of harm. Closing a poorly performing nursing home, for example, presents real risks to patients from the process of relocation. MLK Hospital remained open for years despite public outrage over high profile deaths and injuries. A two-tiered system of care persisted for years in Louisiana despite widespread concerns over patient care. The notion that running health care decisions through a government filter will purify the outcome or always protects the public interest simply does not reflect reality.

Nor does more money does not mean better quality. The Nelson Rockefeller Institute of Government recently issued a report, *Medicaid and Long-Term Care: New York Compared to 18 Other States*. It concludes, "[u]nfortunately, New York's broad range of services and higher spending have not produced a higher quality of care. The state is about average or slightly above average on measures of quality. The comparisons in this report show that New York has room to improve quality and lower costs."[8]

We certainly see every day how poor quality increases costs. The journey into the long-term care system often begins with a senior who is on too many prescription drugs becomes disoriented, falls and breaks a hip. A person with a disability who did not get

[7] Reuters, "Walgreen to cut Washington state Medicaid business," March 30.
[8] The New York Health Policy Research Center, Medicaid and Long-Term Care: New York Compared to 18 Other States, prepared for the New York State Department of Health, February 2009, p. 14.

the properly equipped wheelchair is at risk for skin problems that can lead to pressure ulcers and hospitalization. In one study, the actuarial firm Milliman, Inc. estimated that 25 percent of hospitalizations for Wyoming's long-term care population were avoidable.[9]

Transformation of Medicaid Long-Term Care Should be Included in Reform. Long-term care is an important but all too often overlooked component of health care reform. About one-third of Medicaid spending, or about $100 billion in FY 2007 went to long-term care.[10] Over the next 10 years, Medicaid long-term care spending is projected to grow at an average rate of 8.6 percent per year.[11] At this rate, Medicaid will spend a cumulative total of $1.7 trillion on long-term care between 2008 and 2017.

Fortunately, we now have more than 25 years worth of experience in home and community based services (HCBS) waivers. Today, every state has at least one HCBS waiver and there are approximately 300 such waivers in operation. New Jersey was one of the original "cash and counseling" states. Arizona and Texas are leaders in integrating long-term care and acute medical care through managed care contracts. Within Medicaid, there has been some shift in where long-term care dollars are spent. In FY 2000, 72 percent of Medicaid long-term care expenditures went to institutional care and just 28 percent to community based services.[12] The overall distribution of FY 2007 expenditures had changed to 58 percent institutional and 42 percent community-based.[13]

The AARP Public Policy Institute has recently published its *2009 Across the States: Profiles of Long-Term Care and Independent Living*. Among its ten key findings, AARP estimates that, "[o]n average, Medicaid dollars can support nearly three older people and adults with physical disabilities in home and community-based settings for every person in a nursing home."[14]

Reform should offer more alternatives to Medicaid in order to divert people from needing Medicaid in the first place and Medicaid itself must be rebalanced. In this respect, Vermont provides a model for serious consideration. Patrick Flood, Deputy Secretary of the Vermont Agency of Human Services, has described how Vermont has abandoned the out-dated Medicaid structure of long-term care, and leveled the playing field between institutional and home care with the option of self-direction:

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[9] Bruce Pyeson, Kathryn Fitch, and Susan Panteley, *Medicaid Program Redesign: The Long Term Care and Developmentally Disabled Programs*, Milliman, Inc., September 15, 2006, p. 12.
[10] Office of the Actuary, Centers for Medicare and Medicaid Services, 2008 Actuarial Report on the Financial Outlook for Medicaid, October 17, 2008, p. 10.
[11] OACT, p. 17.
[12] Suzanne Crisp, Steve Eiken, Kerstin Gerst, Diane Justice, Medstat, *Money Follows the Person and Balancing Long-Term Care Systems: State Examples*, prepared for the Centers for Medicare and Medicaid Services, September 29, 2003, Appendix 1, p. 15.
[13] Brian Burwell, Kate Sredl, and Steve Eiken, Thomson Reuters, *Medicaid Long-Term Care Expenditures in FY 2007,* September 26, 2008, p.1.
[14] Ari Houser, Wendy Fox-Grage, and Mary Jo Gibson, *AARP, Across the States: Profiles of Long-Term Care and Independent Living*, 8th Edition, p.17.

In 2005, Vermont received approval from CMS for an 1115 Waiver to re-design our Medicaid long term care system. The goals for the Waiver were to:

- Provide equal access to either a nursing home or home based care services
- Serve more people
- Manage the overall costs of long term care.

Three years later, it is clear that the Waiver has succeeded beyond what Vermont hoped for. We are serving many more people than we could have under the old system. The number of new persons we can admit each year to our home based alternative programs has grown 2-3 times over what we could in the old system. Nursing home use continues to decline gradually. Overall costs of the system have remained manageable.[15]

Flood summarized the Vermont experience: "The beauty of Vermont's approach is that it turns out our theory is correct: more people, given the choice, will choose home based care, and less money will be spent on nursing homes. Thus we can shift money from the nursing home side of the ledger to the home based side and not spend more than was planned, but still serve more people overall."[16]

Millions of Americans served by Medicaid are also clients of other government programs such as the Supplemental Security Income (SSI) program, Food Stamps, housing assistance, mental health, aging, and even transportation programs. All of these programs are part of the long-term care continuum and we should view them as a cohesive system rather than individual, unconnected parts which is the way these programs are currently organized. Better coordination of current coverage would certainly increase access, improve quality, and lower costs. Milliman observes that, "[m]uch of the data collected and information reported about the LTC and DD programs are intended to demonstrate compliance with entitlement rules rather than support care management. A future that provides more efficient, better quality care will have strong capabilities to manage care processes."[17]

There clearly are differences between the elderly and people with disabilities in the use of long-term services and supports when we examine the length of time the two populations use LTSS and the array of services. However, policies for both populations should be the same: they should be person-centered and money should follow the person. Young adults with disabilities are more likely than seniors to be interested in supports that will led to employment, for example. But at the federal level, we should avoid making artificial policy distinctions that could impede the choices and preferences of either population. Some current federal policies unnecessarily complicate the delivery of services to those who rely on them. For example, a person's benefits can change solely because he had a birthday.

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[15] Statement of Patrick Flood at The Heritage Foundation, "Workable Solutions for Long-Term Care," September 24, 2008.
[16] Ibid.
[17] Pyenson et. al., p.2.

Community care for the developmentally disabled has progressed more rapidly than for the elderly and physically disabled. Community based care for the developmentally disabled now accounts for 63 percent of Medicaid long-term expenditures on their behalf while 69 percent of long-term care expenditures for the elderly and physically disabled still go to institutions.[18]

Why has community care progressed more rapidly for the people with developmental disabilities than for our seniors? A better understanding of these changes and differences will assist in identifying how current policies should be changed.

First, the overwhelming credit goes to families. The shift from institutional care to community services reflects their preferences and demands. Families spoke and states responded, though some states faster than others. Long-term care should be properly viewed as a matter of personal liberty and freedom, a family issue, and a social issue as well as a health care issue. They have moved their loved ones out of institutions and, in many cases, on to self-direction. When long-term care is still viewed as a medical model, the progress has been slower. Choice and self-direction improves access and quality while lowering the cost. That is a successful formula that families embrace.

Second, the financial relationships are different. Government needs to acknowledge that its own fragmentation of programs and philosophy of dependency in which providers, rather than people themselves are the decision-makers may be contributing factors as to why the majority of funding for the elderly and physically disabled still goes to institutional care. The institutional bias of Medicaid in which a nursing home bed is an entitlement but supports at home are optional are reinforced by financing advantages of institutions and relationships between institutions. In many states, institutions themselves help finance the cost of Medicaid through upper payment limits and provider taxes. Because they can be a source of the nonfederal share of the cost of Medicaid, they have an advantage when it comes to making budgetary decisions at the state level. Furthermore, institutions, especially in many rural areas in particular, nursing homes are major sources of employment, giving the mutual business interests of owners and workers a powerful political voice.

A third reason is the professionalization of community based services within the developmentally disabled community. Organizations have moved out of someone's basement or the church daycare into sophisticated operations. There are other reasons as well, but whatever the reason is, the central focus should be on leveling the playing field between institutional and non-institutional care. To achieve this, Title XIX itself will need to be amended and reorganized. Long-term care should have its own distinct part within Title XIX. The current distinctions between "mandatory" long term care services and "optional" long term care services should be eliminated. After more than 25 years of experience with home and community based waivers, it is time to recognize the obvious. Home and community based care works and states should not have to rely on waivers

[18] Burwell et. al., Table, "Distribution of Medicaid Long Term Care Expenditures for DD services, Institutional vs. Community-Based Services, FY 2007"and Table, Distribution of Medicaid Long Term Care Expenditures for A/D services, Institutional vs. Community-Based Services, FY 2007.

from Washington to provide it. However, the budget scorekeepers at the Congressional Budget Office (CBO) and the Office of Management and Budget (OMB) generally view greater state flexibility in Medicaid will increase costs. Thus, flexibility will need to be coupled with financing reform as well.

Broad-based solutions will require improvement in all of the current efforts in long-term Medicaid, our retirement systems, and private long-term care coverage. Part of the solution to easing the pressures on Medicaid is for Americans to better prepare for their own retirement needs.

There is great attention to the aging of the "baby boomers" and to the rapidly growing population over the age of 75 where the need for long-term care increases. The age and functional abilities of the person are not the only determinant in whether a person will seek long-term care services and supports. What happens to someone else also matters. That is, family members are the greatest source of support, typically, one spouse caring for the other or an adult child caring for her parent. Broad based solutions should focus on keeping families together for as long as possible.

Better transition planning can lower costs. System redesigns should focus on delaying entry into institutional care or reducing the length of stay in an institutional setting. We should also help ensure a sense of security for families by helping a person with disabilities build assets for their future needs. Today, the message from Medicaid and SSI to individuals and families is don't work, don't build assets, don't plan because if you do, you will lose eligibility. We should reverse this by creating special accounts for people with disabilities to build assets. The Bush Administration proposed such accounts called Living with Freedom, Independence, and Equality (LIFE) Accounts. LIFE accounts would be tax exempt and would not be counted in determining eligibility for Medicaid or SSI. Families could draw some funding out of the Account for incidental items, perhaps 10 percent annually, without penalty. The Account would then be used for future cost of care if the person needs to go into an institutional setting.

LTSS Grant Under New Part B of Medicaid. Reform should assist in the transformation of long-term care from institutional to person-centered supports and services. The current mandatory/optional services for long term care should be replaced by a new Part B of Medicaid under which long term services and supports (LTSS) are offered on an equal basis as under the Vermont model. States should be allowed to move away from the institutional level of care to a functional needs assessment system based on prevention, low, intermediate, and high needs. States should be required to offer families the opportunity to self-direct their long term services and supports. Federal rules on important policies such as spousal impoverishment protections, eligibility, and nursing home quality standards would be preserved to continue to hold providers and states accountable.

Medicaid long-term services and supports would be funded through a dedicated but capped LTSS grant that is stable, predictable, indexed, and guaranteed. States would have the incentive to adopt new delivery options through the conversion of the current

matching system to a maintenance of effort requirement (MOE). States therefore could improve service delivery and save state dollars without losing federal dollars.

States need a more flexible financing arrangement within existing funding levels to be able to level the playing field that also provides them with the ability to work outside the lines of current federal law and regulations. There can be good reasons to want to deviate from the current payment rules. For example, government generally does not want to pay providers for an empty bed. But to shift to community care while maintaining quality within institutions, a state would benefit from flexibility which would allow it to offer a funding stream that puts some nursing homes on a glide path to closure. The federal government would be more favorable to states experimentation with "pay for performance" if it did not have to take the risks connected with open-ended funding commitment.

The current match system works against the interests of what we should be trying to accomplish—greater value at lower costs. States are under tremendous pressure to maximize federal dollars. Medicaid needs a neutral approach in which states can reform their long term services and supports system but maintain a guaranteed stable and predictable source of financing from the federal government. Investment in information and education will provide families with greater emotional security that there will be a continuum of care that supports the health, security, dignity, and individuality of their loved ones.

Response to Concerns over Capped Funding. Over the years, criticism of and opposition to funding caps in Medicaid have generally focused on three areas:

1. states would be handicapped to respond to unforeseen events that would increase eligibility. Hurricane Katrina, SARS, and HIV/AIDS have been offered as reasons to oppose capped funding.
2. there could be medical breakthroughs that could be very expensive, putting states at risk for high cost technology.
3. states have little control over the cost drivers of health care making capped funding an unacceptable risk.

None of these objections particularly apply to the area of long-term care. These three reasons pose little risk in long-term care in which populations are stable and predictable. Long-term care is more high touch than high tech. And in the area of long-term care, states have considerable control over how long-term care is delivered, which is why there are such great differences among the states in per capita spending and the distribution between institutional and community-based care.

Summary. The Health Subcommittee has it right—the debate over health care reform should focus on how much families will save. Our lives and liberties are at stake. Unfortunately, President Obama's pledge to save $2,500 for American families seems to have been misplaced. The current timing and process for considering health care reform has it backwards. Congress is focused on the budget resolution that frames how much the

federal government will spend. The details of policy should be clearly laid out first so the Congressional Budget Office, the Office of the Actuary, and outside actuarial experts such as Milliman and Lewin can model the impact on savings, costs, sources of financing, and enrollment well in advance of floor action in either the House of Representatives or the Senate. For savings to be realized, Congress should concede now that the entitlement programs must also be reformed instead of pushing off those realities for another year. Medicaid's current financing and benefit structure is an impediment to transformation of long-term care from an institution-based, provider-driven medical model to a person-centered, consumer-directed model.

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